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EAP SUPERVISORY REFERRAL FORM

The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee's poor work performance when there is reason to believe that the cause may be due to a personal/medical problem. Additionally, please note that the EAP vendor will inform the State's EAP Coordinator of each instance where an employee fails to attend a scheduled EAP counseling session. **THIS FORM AND ALL SUPPORTING DOCUMENTATION MUST BE SUBMITTED TO THE EAP IN DUPLICATE. IF DOCUMENTATION DOES NOT EXIST, PLEASE PROVIDE A SYNOPSIS EXPLAINING THE BASIS FOR REFERRAL. DO NOT SUBMIT WITHOUT ONE OR THE OTHER.**

(Please print in ink, or type) REFERRAL DATE _____

EMPLOYEE'S NAME _____
(Please circle: Mr./Mrs./Ms.)

ADDRESS _____ HOME PH. _____
(City/County, State, Zip Code)

CLASSIFICATION _____ WK. PH. _____

GRADE _____ EOD _____ DOB _____ CELL PH. _____

DEPARTMENT/AGENCY NAME _____

WORK ADDRESS _____
(Zip Code)

WORK HOURS/SHIFT _____ DAYS OFF _____
(Please use ***non*-military** time)

REFERRED BY _____ TITLE _____

PHONE _____ FAX _____

AGENCY EAP REPRESENTATIVE _____ PH. _____

TITLE _____ FAX _____

_____ Mailing Address _____
AGENCY EAP REPRESENTATIVE'S SIGNATURE _____

_____

REASON FOR REFERRAL

***First*, check off which type of referral this is. *Next*, check off the corresponding areas that are relevant to this referral; *then* attach documentation or synopsis supporting areas checked and overall reason for this referral. This is a:**

I. ☐ **SUBSTANCE ABUSE REFERRAL**
VIOLATION OF GOVERNOR'S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE:
_____ Failed random drug test _____ Alcohol related conviction
_____ Other _____

II. ☐ **MENTAL HEALTH REFERRAL**
ATTENDANCE *(Please place numbers where numbers are requested)*:

_____ Number of days absent past 12 mos.
_____ Pattern (e.g., Mondays, Fridays, after paydays, before and after holidays)
_____ Number of extended lunches past 6 mos.
_____ Number of times late past 6 mos.
_____ Other _____
_____

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JOB PERFORMANCE *(This area must be impacted for referral eligibility, with supporting documentation attached for items checked)*:

_____ Lower quality of work
_____ Decreased productivity
_____ Increased errors
_____ Impaired judgment/memory
_____ Erratic work patterns
_____ Failure to meet schedules
_____ Inability to concentrate
_____ Other _____

BEHAVIOR DEMONSTRATED WITH RESPECT TO JOB PERFORMANCE:

_____ Avoids supervisors/coworkers
_____ Less communicative
_____ Unusually sensitive to advice/constructive criticism
_____ Unusually critical of supervisor/coworkers/employer
_____ Loss of interest
_____ Frequent mood swings
_____ Disregard for safety
_____ Other _____

DOMESTIC VIOLENCE: _____

Have the above issues been discussed with employee? (Yes)_____ (No)_____

Has employee been referred to State Medical Director? (Yes)_____ (No)_____

If yes, when? *(Please attach relevant documents)* _____

IF EMPLOYEE INTENDS TO PARTICIPATE, THIS REFERRAL *CANNOT* BE PROCESSED WITHOUT "YES" INDICATED BELOW AND EMPLOYEE'S SIGNATURE

I understand that my employer is referring me to the State Employee Assistance Program. I also understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have seen this referral and all documentation contained therein.

_____ YES, *I will* participate in the Employee Assistance Program. My health insurance carrier is:

_____

_____ NO, *I will not* participate in the Employee Assistance program.

_____ _____
Signature Date

Your agency EAP Representative should forward this form and all supporting documentation *IN DUPLICATE* to:

Maryland Department of Budget and Management
Employee Relations Division
Employee Assistance Program
301 W. Preston Street, Room 607
Baltimore, Maryland 21201

or Fax to: 410-333-7603

If you have questions, please contact the Employee Assistance Program at 410-767-5846.

FAILURE TO LEGIBLY AND FULLY COMPLETE THIS FORM WILL RESULT IN APPOINTMENT DELAY

Providing your social security number will help us verify your identity. If you do not provide this information, your referral will still be processed. Your SSN will be kept confidential in accordance with federal and State laws and regulations and the Maryland Public Information Act (SG 10-624c).